Acceptable POC M. Nelson 6/1/10

PRINTED: 04/16/2010
FORM APPROVED

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4208AGC	A. BUILDING _____ B. WING _____	C 03/31/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS VEGAS HOME SWEET HOME	2615 LINDELL ROAD LAS VEGAS, NV 89146

Changed to 3/9/10 in ACC & ACO

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility on 3/9/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 14 Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness, six Category I and eight Category II residents. The census at the time of the survey was six. Complaint #NV00024615 was substantiated. See Tag Y0175	Y 000		
Y 175 SS=G	449.209(4)(b) Health and Sanitation-Hazards NAC 449.209 4. To the extent practicable, the premises of the facility must be kept free from: (b) Hazards, including obstacles that impede the free movement of residents within and outside the facility. This Regulation is not met as evidenced by: Based on observation and interview on 3/9/10, the facility failed to ensure the premises of the facility was kept free from hazards for 1 of 6 Residents (Resident #1).	Y 175		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Peggy Lindell — TITLE: Administrator — (X6) DATE: 5/26/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

05-25-10:03:58PM: Acceptable

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Y 175	Continued From page 1 Findings include: Resident #1 fell and broke his hip when he attempted to transfer from his bed to a chair. During an onsite visit on 3/9/10, it was observed the bed belonging to Resident #1 was on wheels which were not locked or on castor holders to prevent the bed from moving. When a small amount of pressure was applied to the bed, it slid across the floor. All eight resident beds were on wheels that were not locked, or on castor holders. During an interview on 3/9/10, Resident # 5 stated her bed was unstable and slid easily upon touch. Severity: 3 Scope: 1	Y 175	Please be advised that all wheels from all the beds were removed attached see photos. Administrator will monitor that all beds do not have wheels to prevent beds from moving.	Okay MW 6/1/10

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STATE FORM 6899 LNW711 If continuation sheet 2 of 2